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Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover

Unhealthy foods, non-communicable diseases and the right to health

Summary

In the report submitted to the Human Rights Council pursuant to its resolution 24/6, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health draws links between unhealthy foods and diet-related non-communicable diseases (NCDs). The Special Rapporteur highlights the urgent need for States to address structural changes in the food environment, which negatively impact individuals' enjoyment of the right to adequate and nutritious food – an underlying determinant of the right to health. Global trade, increased foreign direct investment (FDI) in the food sector and the pervasive marketing of unhealthy foods have increased the consumption of unhealthy foods, which have been linked to diet-related NCDs.

The Special Rapporteur outlines a number of policies to increase the availability and accessibility of healthier food options, including through fiscal policies and the regulation of marketing and promotion of unhealthy foods, as well as increasing information and awareness about the health risks posed by unhealthy foods. He observes States' obligations in ensuring the respect, protection and fulfilment of the right to health, and points to the responsibilities of the food industry in refraining from producing, marketing and promoting unhealthy foods. He also stresses the need for various accountability and remedial mechanisms by which individuals can seek redress to violations of their right to health, and underlines the importance of international assistance and cooperation in the prevention and reduction of the increasing burden of diet-related NCDs.

The Special Rapporteur concludes his report with a set of recommendations, aimed

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at States and the food industry, to take concrete steps to reduce the production and consumption of unhealthy foods and increase the availability and affordability of healthier food alternatives.

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I. Introduction

1. The right to health not only embraces within its scope such underlying determinants of health as an adequate supply of safe food, but its realization is also inextricably linked to the fulfilment of the right to food. Access to nutritiously safe food as an underlying determinant of the right to health is connected with the concepts of food security and nutrition security. Food security is defined by the Food and Agriculture Organization of the United Nations as the situation where "all people, at all times, have physical and economic access to sufficient, safe and nutritious food necessary to meet their dietary needs and food preferences for an active and healthy life".[1] The Committee on the Economic, Social and Cultural Rights has held that one of the core State obligations under the right to health includes ensuring "access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone".[2] On the legal obligations under the right to food, the Committee similarly observed that: "Every State is obliged to ensure for everyone under its jurisdiction access to the minimum essential food which is sufficient, nutritionally adequate and safe, to ensure their freedom from hunger."[3] This concomitant obligation is increasingly important, as unhealthy foods have been implicated in the growing global burden of NCDs.

2. More than 36 million people die from NCDs every year. NCDs have outstripped communicable diseases as the leading cause of death in most parts of the world. Four main diseases – cardiovascular diseases, cancers, chronic respiratory diseases and diabetes – account for a majority of NCD-related deaths. Unhealthy diets are one of the primary modifiable risk factors associated with NCDs and account for 2.7 million deaths annually.[4] Low- and middle-income countries suffer a greater burden of NCD mortality, with 80 per cent of all NCD deaths occurring in these countries.[5] Unhealthy diets are also linked to high rates of obesity, a growing global epidemic that kills around 2.8 million people a year and is a known risk factor for NCDs.[6]

3. Diets high in intake of foods such as burgers, pizzas, red meats, crisps, biscuits, salty snacks, sugary drinks that contain high levels of sugar, salt, trans-fats and saturated fats are known to pose a greater risk for obesity and NCDs.[7] Most of these foods are ultraprocessed,[8] ready to eat but energy-dense and containing empty calories devoid of nutritional value. Unhealthy foods consumed in small quantities and in addition to healthier sources are not necessarily harmful to health. However, given their high availability and

[1] FAO, World Food Summit Plan of Action, para. 1 (1996).

[2] CESCR, General Comment No. 14, E/C.12/2000/4, para. 43(b).

[3] CESCR, General Comment No. 12, E/C.12/1999/5, para. 14.

[4] World Health Organization (WHO), "Unhealthy diets & physical inactivity", NMH Fact Sheet, June 2009. Available from http://www.who.int/nmh/publications/fact_sheet_diet_en.pdf.

[5] WHO, *Global Status Report on Noncommunicable Diseases 2010* (Geneva, 2010, reprinted in 2011), p. 9.

[6] WHO, "10 facts on obesity", available from http://www.who.int/features/factfiles/obesity/facts/en/index1.html.

[7] M. Tokunaga *et al.*, "Diets, nutrients and noncommunicable diseases", *The Open Nutraceuticals Journal*, vol. 5 (2012), p. 152.

[8] Rob Moodie *et al.*, "Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries", *The Lancet* (2013), vol. 381, No. 9867, p. 671: "Ultra-processed products are made from processed substances extracted or 'refined' from whole foods – e.g. oils, hydrogenated oils and fats, flours and starches, variants of sugar, and cheap parts or remnants of animal foods – with little or no whole foods."

palatability, and due to aggressive marketing, they have replaced healthier foods in diets.[9] This is a particularly worrying trend for low- and middle-income countries, as the rate of consumption of unhealthy foods for such countries is projected to outpace high-income countries.[10] While excess calories consumed from unhealthy foods may be expended through physical activity, the shift in technology from labour-intensive to service-oriented occupations and changes in modes of transportation have resulted in sedentary lifestyles and thereby reduced physical activity and energy expenditure.[11]

4. The processes of globalization, in particular trade and FDI in food processing, retailing, and food advertising and promotion, have been increasingly associated with driving shifts in dietary patterns towards those closely linked with NCDs.[12] This is also demonstrated in the increasing presence of transnational food and beverage companies in a number of countries, particularly developing countries, and their pervasive marketing of unhealthy foods.[13] While public policy responses are critical to addressing unhealthy diets by focusing on population-wide responses that alter purchasing and consumption patterns, there has been much less emphasis on addressing structural changes to the food system that largely affect people's diets.[14]

II. Impact of globalization on food systems

5. The policies of globalization have played an important role in increasing the free flow of unhealthy foods between countries. Changes in the food system are now largely driven by transnational corporations (TNCs), including food and beverage companies and supermarket chains, which have altered diets from traditional and minimally processed foods to ultraprocessed ones. In fact, 75 per cent of the world's food sales constitute processed foods, whose largest manufacturers control more than one third of the global market.[15] TNCs have therefore been a critical link in the transition from minimally processed to ultraprocessed foods. They also greatly influence the sale and consumption of unhealthy foods in comparison to promoting the availability and affordability of healthy foods within the food system.[16]

6. Industrial technology has contributed to the dominance of TNCs in the modern food system. The use of agrochemicals and hybrid seeds in farming and extraction technology in food processing have allowed for large-scale food production at substantially lower costs.[17] The addition of high amounts of salts, saturated- and trans-fats to ultraprocessed foods have

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[9] *Ibid.*, pp. 671–672.

[10] David Stuckler *et al.*, "Manufacturing epidemics: the role of global producers in increased consumption of unhealthy commodities including processed foods, alcohol and tobacco", *PLOS Medicine*, vol. 9, No. 6 (2012), p. 2.

[11] Barry M. Popkin, "Global nutrition dynamics: the world is shifting rapidly toward a diet linked with noncommunicable diseases", *American Journal of Clinical Nutrition*, vol. 84, No. 2 (2006), pp. 289–298.

[12] Corinna Hawkes, "Uneven dietary development: linking the policies and processes of globalization with the nutrition transition, obesity and diet-related chronic diseases", *Globalization and Health*, vol. 2, No. 4 (2006).

[13] *Global Status Report on Noncommunicable Diseases 2010* (see footnote 5 above), Chapter 2, NCDs and Development, p. 33.

[14] Sharon Friel *et al.*, "Measuring progress on diet-related NCDs: the need to address the causes of the causes", *The Lancet* , vol. 381, No. 9870 (2013), pp. 903–904.

[15] "Profits and pandemics" (see footnote 8 above), pp. 671–672.

[16] "Manufacturing epidemics" (see footnote 10 above), pp. 1–2.

[17] Tim Lang, "Food industrialisation and food power: implications for food governance", Gatekeeper Series No. 114 (International Institute for Environment and Development, 2004), pp. 4–5.

increased the shelf life of such foods and reduced transportation costs, making them more profitable.

7. The 1980s "structural adjustment programmes" of the International Monetary Fund and the World Bank compelled developing countries to open up their markets, including the food sector, to foreign trade as a part of loan fulfilling conditions. Agreements negotiated at the World Trade Organization sought further market integration by reducing tariffs and non-tariff barriers to trade, curtailing export subsidies and removing protections of domestic industry to promote the freer flow of goods and services.[18] These policies were implemented as a means of increasing the efficiency of the food system in producing the foods that people needed and wanted, but they had significant effects on the types of available foods and their costs. As a result, there has been a drastic increase in production of certain products relative to others. For example, there was a substantial increase in the global production of vegetable oils such as partially hydrogenated soybean oil, a source of trans-fats, and palm oil, a source of saturated fats.[19] Similarly, grains such as corn are produced in larger quantities to cater to the food processing industry to produce sweeteners like high-fructose corn syrup, substantially increasing global calorie consumption from such sweeteners (A/HRC/19/59, pp. 13–14). Studies show that countries adopting market deregulation policies experience a faster increase in unhealthy food consumption and mean body mass index, an indicator of obesity.[20] In furthering the goals of market expansion and profits, critical focus areas of health such as diets and nutrition have not been given due consideration.[21]

8. Rise in levels of FDI in the processed foods sector is one such factor that allows for greater exposure to unhealthy foods in low- and middle-income countries.[22] FDI is one of the mechanisms by which TNCs enter developing countries. FDI enables companies to purchase or invest in food-processing companies in other countries, which then produce processed foods for the domestic market. This circumvents import tariffs on processed foods and reduces the cost of transportation. FDI has been more crucial than trade in increasing sales of processed foods in developing countries.[23] For example, in some emerging markets, the processed food industry is amongst the top sectors attracting FDI.[24] Most of the sales for popular soft drink and fast food brands also come from developing countries.[25]

9. Supermarkets and large food chains have largely replaced fresh food markets as a major source of food supply in most countries,[26] and at a faster rate in developing than

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[18] Corinna Hawkes *et al.*, "Linking agricultural policies with obesity and noncommunicable diseases: a new perspective for a globalising world", *Food Policy*, vol. 27 (2012), pp. 344–345.

[19] *Ibid.*, p. 345.

[20] Roberto De Vogli *et al.*, "The influence of market deregulation on fast food consumption and body mass index: a cross-national time series analysis", *Bulletin of the World Health Organization*, vol. 92 (2014), pp. 99–107A.

[21] "Diets, nutrients and noncommunicable diseases" (see footnote 7 above), p. 148.

[22] "Manufacturing epidemics" (see footnote 10 above), p. 5.

[23] Corinna Hawkes, "The role of foreign direct investment in the nutrition transition", *Public Health Nutrition*, vol. 8, No. 4 (2005), pp. 357–365.

[24] Kakali Majumdar, "Foreign direct investment in Indian food processing industry", *Asian Journal of Research in Business Economics and Management*, vol. 2, No. 4 (April 2012), p.113. Available from http://www.ajsh.org/setup/business/ paper139.pdf.

[25] Corinna Hawkes, "Marketing activities of global soft drink and fast food companies in emerging markets: a review", *Globalization, Diets and Noncommunicable Diseases* (Geneva, WHO, 2002), p. 1.

[26] Barry M. Popkin *et al.*, "The global nutrition transition and the pandemic of obesity in developing countries", *Nutrition Reviews*, vol. 70, No. 1 (2012), p. 8.

developed countries.[27] Supermarkets based in North America and Europe have invested heavily in Africa, Asia, Central and Eastern Europe and Latin America. Supermarkets are now the primary food retailers in Latin America.[28] In one country, approximately three quarters of the FDI flows towards highly-processed foods like soft drinks, snacks and mayonnaise.[29]

III. Promotion and marketing of unhealthy foods

10. Global food promotion, marketing and advertising are closely linked with globalization, leading to dietary transitions towards unhealthy foods. The aim of food marketing is to increase demand for products by making people develop the habit of consuming the product regularly. Aggressive expansionist strategies pursued by TNCs in emerging economies over the last few decades have increased the visibility and familiarity of global food brands, which are then leveraged to increase consumption of these products. Specific marketing tools are used to increase consumption by ensuring the presence of global food brands in as many places as possible at affordable prices, while expanding the variety of their products to suit local tastes and purchasing capacities. In order to cater to some rural areas and low-income populations, soft drink companies have invested in smaller bottles at lower prices to create acceptability of the product. In other places, portion sizes are increased to encourage greater consumption.[30] At an individual level, increased purchasing power and the convenience of ready-to-eat products promote the consumption of unhealthy foods. At a population level, the aggressive and systematic marketing strategies used by TNCs fuel this demand.[31]

11. The food industry spends billions of dollars on persistent and pervasive promotion and marketing of unhealthy foods. TNCs often enter into exclusive contracts with fast food outlets to sell their foods. Varied pricing strategies are used as a mechanism to elicit demand for unhealthy products. Supermarkets have also been found to provide more price discounts for unhealthy foods compared to healthy foods.[32]

IV. State obligations to respect, protect and fulfil the right to health

12. With respect to the availability and accessibility of nutritionally adequate and safe food, both the right to health and the right to food cast obligations on States. Under the right to health framework, States have a core and non-derogable obligation to ensure access to the minimum essential food that is nutritionally adequate to ensure freedom from hunger for everyone. Pertinently, the right to food framework requires States to ensure the availability and accessibility of food in a quantity and quality to satisfy the individuals'

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[27] Abay Asfaw, "Supermarket purchases and the dietary patterns of households in Guatemala", IFPRI Discussion Paper 00696 (Washington D.C., International Food Policy Research Institute, 2007), p. 1.

[28] Ronald Labonté *et al.*, "Framing international trade and chronic disease", *Globalization and Health*, vol. 7, No. 21 (2011), p. 3.

[29] "The role of foreign direct investment in the nutrition transition" (see footnote 24 above), p. 360.

[30] "Marketing activities of global soft drink and fast food companies ..." (see footnote 26 above), pp. 8–12.

[31] "Profits and pandemics" (see footnote 8 above), p. 372.

[32] University of East Anglia, "Supermarket offers: a healthy choice for consumers?", 21 November 2012. Available from http://www.uea.ac.uk/mac/comm/media/press/2012/November/supermarkets-offers-paul-dobson.

dietary needs, and which contain a mix of nutrients for physical and mental growth, development and maintenance, and physical activity that are in compliance with human physiological needs at all stages of life.

13. The International Covenant on Economic, Social and Cultural Rights provides for progressive realization of the right to health, which means that States have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of the highest attainable standard of health. States should therefore formulate a time-bound plan by taking immediate and continuing steps to the maximum of their available resources. This obligation can be fulfilled, *inter alia*, by formulating polices related to health, as well as to sectors such as trade and agriculture. In particular, the right to health framework requires States to take measures to prevent diet-related NCDs and provide equal and timely access to primary health care. Thus, in order to ensure the three types of obligations under the right to health, namely to respect, protect and fulfil it, States should not only provide nutritious food, but also institute measures in all areas of policymaking to reduce the burden of diet-related NCDs.

14. The obligation to respect the right to health is a negative duty of the State to refrain from interfering with people's enjoyment of their right to health. It recognizes the right and autonomy of individuals to make informed decisions with respect to their health. The obligation not to intervene in individual decision-making does not, however, imply a disengaged approach by States towards laws and policies concerning the food industry. Feasible alternatives should be made available and accessible to individuals from which to choose a healthy diet.

15. States also have the obligation to protect people from violations of their right to health from activities of non-State actors, including private food corporations. For instance, States should make sure that advertisements and promotion by food corporations convey accurate and easily understandable information on possible ill effects of their food products. This is important, as withholding or misrepresenting such information is likely to affect people's diet choices, which impacts on the right to health.

16. Fulfilling the right to health is a positive obligation that requires States to adopt a national public health strategy and plan of action towards achieving the highest attainable standard of health. States also have the duty to ensure that information relating to healthy diets is accurate and available to encourage informed choices. In recognizing the close links between food and health, States would need to formulate multisectoral policies that positively affect the availability and accessibility of healthy foods. For instance, States may need to modify their food and agricultural, trade and fiscal policies. Such policies should take into consideration epidemiological evidence of diet-related NCDs and should be implemented and monitored through indicators and benchmarks. However, States should ensure that regulations do not unduly harm small-scale industries. Although it is necessary to ensure that foods produced by small-scale industries are neither unhealthy nor unsafe, regulatory requirements may disproportionately burden them. Alternative approaches, such as community and peer education among consumers as well as small-scale food manufacturers, may be more effective in persuading them to produce healthier foods. For instance, some States have successfully used peer education models in getting street-food vendors to replace harmful vegetable oils with healthier options.

A. Information and awareness-raising

17. As a step to progressively realizing the right to health, States should formulate and regularly update food and nutrition guidelines for a healthy diet for different groups, particularly for vulnerable groups, like children, women and low-income groups. Guidelines should be formulated based on scientific evidence and with the participation of

the community, civil society organizations and other stakeholders. To be effective, dissemination of these guidelines and nutritional information to people in a comprehensible manner is equally important. One regulatory approach that States should consider is the adoption of nutrient profiling models, in which foods are ranked according to their nutritional composition.

18. Education and public awareness programmes can help the population make healthier food choices. Consumer-friendly labelling of food products is a common method to raise awareness and encourage consumers to make informed decisions about their diets. For instance, some States have issued guidance for supermarkets and food and beverage companies to use images such as front-of-pack, "traffic light" food labelling.[33] This creates awareness about healthier food options, impacting positively consumer choice. Traffic light food labelling makes use of red, amber and green colours to indicate high, medium and low content, respectively, of a particular nutrient. As children are particularly vulnerable to increased risk of NCDs in adulthood due to the consumption of unhealthy foods, States should involve schools in teaching children about the benefits of healthy foods in a child-friendly manner.

B. Fiscal policies

19. To reduce the intake of unhealthy foods, States should adopt policies to create disincentives for consuming them. For instance, some States have levied a consumption tax on sugar-sweetened beverages to curb the obesity epidemic, with the revenue raised from sales to be spent on providing drinking water.[34] However, merely increasing the price of unhealthy foods may have a punitive effect on low-income groups. Reducing the price of nutritious food to levels cheaper than or comparable to unhealthy foods would make healthy foods more affordable. For instance, agricultural subsidies benefiting unhealthy foods could be removed and shifted to subsidies for increasing the production of healthier foods. States could take measures, such as tax benefits and focused investments in agricultural production, to incentivize farmers to produce healthier foods like vegetables and fruits (A/HRC/19/59).

20. Procurement policies could be used to encourage farmers to produce fruits and vegetables, guaranteeing profits and making more nutritious diets affordable for low-income groups. For instance, some countries procure food grains at market rates directly from farmers that they then sell to low-income groups at affordable rates, balancing the interests of the farmer and a vulnerable group. Another measure adopted by States has been to encourage localized farming and then procure the produce for schools. This not only enhances local economic development, but also ensures the reduction of unhealthy foods among schoolchildren.[35]

21. Accessibility of healthy foods may not necessarily lead to their higher intake. Even though foods with high nutrition value may be available in areas and spaces alongside less nutritious foodstuffs, consumers may not be attracted to the healthier option based on

[33] NHS Choices, "Food labels", 19 June 2013, available from http://www.nhs.uk/Livewell/Goodfood/Pages/food-labelling.aspx.

[34] Sarah Boseley, "Mexico enacts soda tax in effort to combat world's highest obesity rate", *The Guardian*, 16 January 2014, available from http://www.theguardian.com/world/2014/jan/16/mexico-soda-tax-sugar-obesity-health.

[35] World Food Programme, *Brazil: a Desk Review of the National School Feeding Programme* (July 2007). Available from http://documents.wfp.org/stellent/groups/public/documents/newsroom/wfp207419.pdf.

various factors such as perceived palatability or lack of visibility of healthier options and their benefits. Retail stores and supermarket chains may stock healthy foods, but lesser shelf-space may be allocated to them or they may be placed at the back of the store.[36] This would have a negative effect on consumption patterns in favour of healthier foods. To rectify this, States could urge and require retailers to arrange their products in ways that would attract the consumer to healthier options. States could also promote healthier foods through media and social channels traditionally used by food and beverage companies, from television to Internet advertisements.

C. Policies on marketing and promotion of unhealthy foods

22. To prevent harm to people's health and fulfil their obligation under the right to health, States should put in place national policies to regulate advertising of unhealthy foods. States should formulate laws and a regulatory framework with the objective of reducing children's exposure to powerful food and drink marketing. Such regulations should ensure that the food industry provide accurate and reader-friendly nutrition information when advertising their products.

23. To address the issue of aggressive marketing, some States have supported self-regulation and have allowed food companies to voluntarily regulate their practices related to marketing and nutritional content of unhealthy foods to children.[37] Companies often voluntarily adopt self-formulated guidelines and standards to restrict Government regulation and respond public demands. They have also taken joint initiatives and formulated guidelines for member companies to restrict advertising and promoting practices with respect to children. However, self-regulation by companies has not had any significant effect on altering food marketing strategies.[38] Due to a variety of reasons, such as the non-binding nature of such self-regulation, lack of benchmarks and transparency, inconsistent definition of children and different nutrition criteria, companies may be able to circumvent guidelines, blunting the intended effect of marketing guidelines they instituted.

24. Collaboration between Governments and food corporations has been recommended as an alternative to self-regulation. One of the major reasons cited for promoting partnerships between private food companies and Governments is that food corporations have the ability to promote healthier dietary habits and are therefore a part of the solution to reduce and prevent the obesity epidemic.[39] However, the conflict of interest between the State's duty to promote public health and companies' responsibility towards their shareholders to increase profits renders private–public partnership suspect. In addition, the close relationship between food and beverage companies and Government agencies may lead to a lack of transparency and independence of regulatory authorities, which may

[36] Heart Foundation, *The Supermarket as an Environment for Facilitating Dietary Behaviour Change* (June 2012), pp. 14–15. Available from http://www.heartfoundation.org.au/SiteCollectionDocuments/NHF-Supermarket-rapid-review-FINAL.pdf.

[37] Executive Office of the President of the United States, *Solving the Problem of Childhood Obesity within a Generation: White House Task Force on Childhood Obesity Report to the President*, (Washington D.C., May 2010), Recommendation 2.5. Available from http://www.letsmove.gov/sites/letsmove.gov/files/TaskForce_on_Childhood_Obesity_May2010_FullReport.pdf.

[38] WHO, *Marketing Food to Children: the Global Regulatory Environment* (Geneva, 2004), p. 13.

[39] Institute of Medicine of the National Academies, *Building Public–Private Partnerships in Food and Nutrition* (Washington D.C., 2012), pp. 9–22. Available from http://www.ncbi.nlm.nih.gov/books/NBK97331/pdf/TOC.pdf.

undermine the effectiveness of public–private partnerships in States' efforts to reduce diet-related NCDs.

25. Owing to the inherent problems associated with self-regulation and public–private partnerships, there is a need for States to adopt laws that prevent companies from using insidious marketing strategies. The responsibility to protect the enjoyment of the right to health warrants State intervention in situations when third parties, such as food companies, use their position to influence dietary habits by directly or indirectly encouraging unhealthy diets, which negatively affect people's health. Therefore, States have a positive duty to regulate unhealthy food advertising and the promotion strategies of food companies. Under the right to health, States are especially required to protect vulnerable groups such as children from violations of their right to health. To reduce opportunities for targeted advertisements, some States have instituted laws to ban companies from advertising their products to children below a certain age and to limit the availability of unhealthy foods in schools.[40]

D. Policies on foreign direct investments

26. TNCs that manufacture and sell processed foods are making their presence felt globally by reaching consumer groups, which transcend national boundaries through FDI and international trade agreements, thus impacting on the health of transboundary populations. Recognizing this, States need to bring these companies within their regulatory framework. States may impose health-related conditions on investments by TNCs and require them to adhere to domestic standards on nutrition, advertisement and marketing.[41] For instance, States may condition investments by foreign retail chains on a requirement to make available healthy foods in their stores.

27. However, regulating FDI by TNCs through conditions on the kind of food they produce may affect the decision of TNCs to invest in these States.[42] Some States, especially low- and middle-income countries that rely on foreign investments may not be able to impose health- or diet-related conditions. States may therefore not give primacy to the health of the population, undermining the full realization of the right to health. There is a need to use other approaches, such as incentivizing the manufacture and sale of healthier alternatives, to protect the right to health of people and still attract FDI.

V. Responsibilities of the food and beverage industry

28. Although international human rights instruments refer to States as primary duty-bearers, non-State actors are also charged with the responsibility to respect the right to health. The International Covenant on Economic, Social and Cultural Rights prohibits the violation of human rights enshrined therein not only by States, but also by any "group or person", clearly implicating the responsibility of non-State actors in the realization of human rights (article 5). The right to health framework further crystalizes this position and provides that while only State parties to the Covenant are thus ultimately accountable for compliance with it, all members of society as well as the private business sector have

[40] Barbara Fraser, "Latin American countries crack down on junk food", *The Lancet*, vol. 382, No. 9890 (August 2013), pp. 385–386.

[41] "The role of foreign direct investment in the nutrition transition" (see footnote 24 above), p. 363.

[42] Neal H. Hooker and Julie A. Caswell, "Trends in food quality regulation: implications for processed food trade and foreign direct investment", *Agribusiness*, vol. 12, No. 5 (September/October 1996), pp. 411–419.

responsibilities regarding the realization of the right to health. In the context of business corporations and TNCs, several guidelines have been adopted internationally that clarify that business corporations and TNCs have the responsibility to respect human rights, which includes the right to health.[43] The responsibilities of business enterprises are independent of the State's obligations to realize its obligations towards human rights and also of corporations' obligations to comply with national laws and regulations.[44]

29. The responsibility to respect the right to health requires the food industry to refrain from engaging in activities that negatively impact the right of people to the highest attainable standard of health. Where States have enacted legislation as part of national health policies to discourage consumption of unhealthy foods and promote healthier options, the food industry has the responsibility to comply with such laws and desist from undertaking activities that would undermine these policies. They should take measures to prevent, mitigate and remedy adverse impacts of their actions. For example, in light of the negative impact of food marketing and promotion activities on children's diets, the food industry has the responsibility to refrain from advertising unhealthy products to children in accordance with national laws and regulations. Failure to exercise such restraint under domestic law may amount not only to a violation of the law, but also of the right to health. Similarly, the food industry should desist from promoting false or misleading health claims about their products, consistent with their responsibility to respect the right to health. Health claims about food products have often been shown to be unverifiable and deceptive about relative health benefits. Moreover, even where unhealthy ingredients like sugar and fat content are replaced with refined starch and promoted as "healthier" food options, they are still processed foods with minor improvement in nutritional quality.[45]

30. Studies have shown that the food industry uses various strategies to undermine public health nutrition efforts. For example, the food industry hires prominent academics for their advisory boards, which may result in findings being more favourable towards the food industry, with the danger that the food industry may use such biased findings to support its claims on nutrition.[46] Other tactics include the funding of front groups (that appear independent, yet are controlled by other organizations), lobbying and instituting lawsuits and threats thereof.[47] It has also been shown that, under the guise of corporate social responsibility to meet their ethical obligations towards society at large, big soft drink companies have attempted to shift the burden of the responsibility to make healthier choices onto consumers instead of addressing their role in creating an unhealthy food environment. Furthermore, corporate social responsibility has also been used by the big soft drink industry as a means to thwart attempts at government regulation and increase sales of their products, particularly to children.[48] Such acts result in a negation of the right to health.

31. As the food industry plays a key role in the global food environment and is recognized as the primary driver of diet-related NCDs, it has a distinct responsibility to take

[43] E/CN.4/Sub.2/2003/12/Rev.2. See also HR/PUB/11/04.

[44] HR/PUB/11/04, Principle II, A.11.

[45] Marion Nestle and David S. Ludwig, "Front-of-package food labels: public health or propaganda?", *Journal of the American Medical Association*, vol. 303, No. 8 (2010), p. 772.

[46] Kelly D. Brownell and Kenneth E. Warner, "The perils of ignoring history: big tobacco played dirty and millions died. How similar is big food?", *The Milbank Quarterly*, vol. 87, No. 1 (2009), pp. 278–279.

[47] See Dr. Margaret Chan, Director-General of WHO, opening address at the Eighth Global Conference on Health Promotion, Helsinki, 10 June 2013. Available from http://www.who.int/dg/speeches/2013/health_promotion_20130610/en/.

[48] Lori Dorfman *et al.*, "Soda and tobacco industry corporate social responsibility campaigns: how do they compare?", *PLOS Medicine*, vol. 9, No. 6 (2012), pp. 3–4.

steps to realize the right to health. While many challenges facing the food system, like environmental pressures such as draughts and floods, are out of the control of the food industry, there are several areas where it can make a positive impact on health by investing in and influencing healthier food choices. To this end, the industry should consider adopting standards to improve the nutritional quality of foods through product reformulation and to improve labelling and information on their products to contribute to healthier diets. The food industry should also invest in research to improve the nutritional content of their products rather than investing in increasing the marketability of existing products.[49] Furthermore, supermarkets and fast food restaurants should take steps to market and promote healthier options. For example, in addition to providing calorie content of meals on menu cards, fast food restaurants should adopt appropriate nutrient profiling models that indicate the nutritional composition of the foods available.

32. In furthering their responsibility to respect the right to health, the food industry should ensure the transparency of nutritional information and composition, an area where thus far the efforts of the food industry have been woefully lacking. The food industry should take concrete steps to ensure that consumers have sufficient nutritional information about their products to aid and promote more responsible dietary decisions. Moreover, creating and implementing mechanisms that promote disclosures of conflicts of interest within their governance structures can contribute towards efforts to ensure transparency of the operations of the food industry. This is of particular relevance where global health funders, who are also non-State actors, are shareholders or sit on the governance boards of the food industry or vice versa.[50]

VI. Vulnerable groups

33. States have a core obligation to protect the right to health of vulnerable and marginalized groups. The present report focuses on three particular groups: children, because of their greater susceptibility to marketing; women, because gendered marketing perpetuates traditional and unequal gender roles; and low-income groups, because healthy food options are not readily available or accessible to them. Other individuals or communities may also face higher risks of diet-related NCDs due to race, gender, indigenous status or place of residence, as well as because of multiple or intersecting vulnerabilities.

A. Children

34. Despite the common association of NCDs with older persons, children are also affected by the full range of NCDs, including heart disease, cancer and diabetes, and by their risk factors such as being overweight or obese.[51] Diet-related NCDs and obesity affect even very young children. For instance, of the 500 million obese people worldwide in 2008,

[49] Marion Nestle and Ted Wilson, "Food industry and political influences on American nutrition", in *Nutritional Health: Strategies for Disease Prevention*, N J Temple *et al.* (eds.), 3rd ed. (Humana Press, 2012), p. 480.

[50] David Stuckler *et al.*, "Global health philanthropy and institutional relationships: how should conflicts of interest be addressed?", *PLOS Medicine*, vol. 8, No. 4 (2011), p. 7.

[51] NCD Alliance, "A focus on children and non-communicable diseases (NCDs)", position paper prepared for the United Nations Summit on Non-Communicable Diseases, New York, September 2011, p. 5.

more than 42 million were children under the age of five, with 35 million of those children in developing countries.[52]

35. Children are particularly vulnerable to diet-related NCDs either because they may be dependent on others, such as parents or schools, for food, or because they are more susceptible to marketing pressures.[53] In addition, unhealthy childhood diets can have severe health consequences later in life because of the early formation of eating habits and preferences and also because childhood NCDs are likely to persist into adulthood. Addressing unhealthy diets as a risk factor for NCDs in children can bring substantial health gains and reduce the burden of health-care expenditure over their entire life cycle.[54]

36. In addition to marketing of unhealthy food targeted at children, including through toy giveaways, competitions, social media, cartoon characters, games, television, movies, interactive websites and in youth-oriented settings such as schools and recreation centres, parents are also often targeted by such pervasive marketing.[55] This is done to encourage parents to buy unhealthy foods for their children. In many cases, the food industry's marketing to children and their parents may be disproportionately aimed at particular racial, ethnic or socioeconomic groups, exacerbating health inequities faced by those groups.[56]

37. Children are also frequently exposed to junk foods in both public and private settings. Food served or sold in institutional settings such as schools may be disproportionately weighted towards junk foods or other foods of limited nutritional value, particularly in school lunch programmes, where funds for healthier foods may be limited.[57] Other places serving children and youth, such as sports centres, may also lack healthy food options. In the private sector, meals designed for children are often high in fat, sugar and salt, and fail to meet children's nutritional needs, especially at fast food establishments. This may be the case even for foods marketed as "healthy" children's meals. Where genuinely nutritious options are available, the default option may still be the unhealthy one.[58]

38. States are urged to implement their obligations regarding children's right to health, which requires States to address obesity in children, limit children's exposure to fast foods and drinks high in sugar and caffeine and other harmful substances, regulate the marketing of such foods and control their availability in schools and other places frequented by children. States should also ensure that effective health education and awareness programmes are targeted toward children, such as countermarketing campaigns or peer education programmes, and that healthy food options and information relating to them are available at institutions serving children, such as schools, paediatric health facilities or youth centres.

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[52] *Ibid*, p. 7.

[53] NCD Alliance, "Children in every policy: recommendations for a lifecourse approach to NCDs", briefing paper, May 2011, p. 2.

[54] "A focus on children and non-communicable diseases (NCDs)" (see footnote 54 above), p. 5.

[55] WHO Regional Office for Europe, *Marketing of Foods High in Fat, Salt and Sugar to Children: Update 2012–2013* (Copenhagen, 2013); Consumers International, *The Junk Food Trap: Marketing Unhealthy Food to Children in Asia Pacific* (London, 2008).

[56] Yale Rudd Center for Food Policy and Obesity, *Fast Food Facts 2013: Measuring Progress in the Nutritional Quality and Marketing of Fast Food to Children and Teens* (Robert Wood Johnson Foundation, Princeton, 2013), p. 63.

[57] Patricia M. Anderson and Kristin F. Butcher, "Reading, writing and raisinets: are school finances contributing to obesity?", National Bureau of Economic Research Working Paper No. 11177, (Cambridge, 2005), p. 5. Available from http://www.nber.org/papers/w11177.pdf.

[58] *Fast Food Facts 2013* (see footnote 59 above), p. 29.

B. Women

39. Unhealthy foods are commonly marketed in gendered ways, perpetuating traditional and unequal gender dynamics to the disadvantage of women. Despite the increase in dual-income or female-breadwinner households, women still bear a disproportionate share of household duties, particularly in preparing meals. This leads to the increased consumption of highly-processed convenience foods, as women have less time but are still expected to be responsible for food provision.[59] Food advertisements often target women about providing cooked meals for their children or by offering aspirational products that are "improved" over traditional diets.

40. Other marketing messages targeted at women may emphasize sexuality and unattainable "desirable" body types to promote unhealthy foods, which not only perpetuate gender stereotypes but also have a negative impact on both physical health, such as diet-related NCDs, and mental health, such as eating disorders.[60]

41. Food policies that emphasize home cooking to improve diets must take into account these gender and labour-force dynamics. Healthy eating programmes should not focus solely on mothers, but must also promote the role of men in food preparation, as well as take into account a diverse range of family arrangements.

C. Low-income groups

42. Although NCDs are often perceived as "diseases of affluence", the relationship between income and diet-related risk factors is complex.[61] Studies have suggested that after a country reaches a per-capita gross domestic product of US$ 2,560, obesity becomes more prevalent in lower-income than higher-income groups,[62] while consumption of unhealthy food is strongly associated with both lower income and lower levels of education in several developed and middle-income countries.[63] The perception that NCDs affect only the wealthy has led to the neglect of the diseases in health policies for low-income persons, to the detriment of their right to health.[64]

43. Low-income groups frequently have poorer diets than other sections of the population,[65] as healthy foods like fresh fruit and vegetables may be unaffordable for them, discouraging their consumption.[66] Many low-income groups, such as shift workers, also

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[59] Patricia Allen and Carolyn Sachs, "Women and food chains: the gendered politics of food", *International Journal of Sociology of Food and Agriculture*, vol. 15, No. 1 (2007), pp. 9–10.

[60] *Ibid.*, pp. 2–4.

[61] Food Research and Action Center, "Do the data show a link between obesity and poverty?", fall 2010, available from http://frac.org/wp-content/uploads/2010/09/do_data_show_obesity_poverty_link_brief.pdf; Carlos A. Monteiro *et al.*, "Socioeconomic status and obesity in adult populations of developing countries: a review", *Bulletin of the World Health Organization*, vol. 82, No. 12 (December 2004), pp. 940–946.

[62] "Socioeconomic status and obesity in adult populations of developing countries" (see footnote above); WHO, *A Framework to Monitor and Evaluate Implementation: a Global Strategy on Diet, Physical Activity and Health* (Geneva, 2008), para. 8.

[63] See WHO Regional Office for the Western Pacific, *Non-Communicable Disease and Poverty: the Need for Pro-Poor Strategies in the Western Pacific Region: a Review* (Geneva, 2007), pp. 29–32.

[64] *Ibid.*, pp. 8–9.

[65] Nicole Darmon and Adam Drewnowski, "Does social class predict diet quality?", *American Journal of Clinical Nutrition*, vol. 87, No. 5 (May 2008), pp 1107–1117.

[66] Mayuree Rao *et al.*, "Do healthier foods and diet patterns cost more than less healthy options? A systematic review and meta-analysis", *BMJ Open*, vol. 3, No. 12 (2013).

tend to lack the time or facilities for cooking, making ultraprocessed, ready-to-eat foods more attractive than healthy foods even if they are not necessarily less expensive.

44. Low-income persons may also be more likely to live in "food deserts", where healthy fresh food options are lacking, or in "food swamps", where there is significantly greater presence of unhealthy foods and unhealthy food marketing. Healthy foods are frequently less available, of lower quality and attractiveness, or more expensive in low-income areas.[67] Conversely, lower-income areas can have up to two and a half times as many fast food stores as higher-income areas.[68] These problems are likely to be compounded by geographical barriers for remote rural communities, poorly served urban slums or where transport between lower-income and higher-income areas is poor.

45. Poor diets tend to have greater consequences for low-income persons than for other groups. Undernutrition early in life may lead to a greater probability of obesity later in life due to a "feast or famine" response that causes the body to hoard fat when it is available.[69] This combination of lack of food security or hunger with the ready availability of calorie-dense junk foods places many low-income communities at particular risk of NCDs, compared to higher-income groups. Psychosocial factors such as stress, higher incidences of other NCD risk factors and less access to preventive care can also increase risks of diet-related diseases such as diabetes, heart disease and hypertension among low-income groups.[70]

46. In combating NCDs, States should therefore ensure that they comprehensively address socioeconomic disparities. They should ensure that food security or poverty reduction plans adequately address the need for healthier food options. They could do so, for example, by increasing availability of fruits and vegetables under food security schemes, incentivizing food retailers to stock healthy foods in low-income neighbourhoods or improving public transport to areas where healthy foods are available. In particular, social programmes aimed at ensuring food and nutritional security can be a useful tool for improving health, if they are sufficiently funded to allow for the purchase of healthy options and are combined with appropriate measures to provide nutrition education and make healthy foods available and accessible to those receiving benefits.[71] Finally, States should work to eliminate inequities in access to primary and preventive care, to lessen the disproportionate effects of unhealthy foods on low-income communities.

VII. Participation

47. The right to health framework requires the participation of the population, especially affected populations, in health-related decision-making at all levels – community, regional and national. States should ensure the participation of affected communities and vulnerable groups in developing food policy and in decision-making regarding food availability and

[67] Policy Link and The Food Trust, *The Grocery Gap: Who has Access to Healthy Food and Why it Matters* (2010).

[68] DD Reidpath *et al.*, "An ecological study of the relationship between social and environmental determinants of obesity", *Health Place*, vol. 8, No. 2 (2002), pp. 141–145.

[69] Gian-Paolo Ravelli *et al.*, "Obesity in young men after famine exposure in utero and early infancy", *New England Journal of Medicine*, vol. 295, No. 7 (1976), pp. 349–353.

[70] Food Research and Action Center, "Food insecurity and obesity: understanding the connections", spring 2011, available from http://frac.org/pdf/frac_brief_understanding_the_connections.pdf.

[71] Food Research and Action Center, "How improving federal nutrition program access and quality work together to reduce hunger and promote healthy eating", February 2010, available from http://www.frac.org/pdf/CNR01_qualityandaccess.pdf.

marketing in places such as schools, workplaces and community centres. Participation empowers people to exercise their right to autonomy and make their own decisions about their dietary health.

48. Meaningful participation has public health benefits and also empowers people in accordance with the right to health approach. States should ensure that spaces are available for children and their parents to provide input on school foods, employees to give input on food at the workplace, or by enabling community or consumer groups to be involved in standard-setting. States should seek broad public consultation to inform policies across sectors, including on agricultural production policies, the regulation of unhealthy foods, nutritional standards in public institutions and for monitoring transparency in food labelling, marketing or promotion.

49. States should encourage community health programmes on diet-related NCDs, such as peer education, community gardening and cooking initiatives, or healthy eating initiatives based at schools, workplaces, primary health-care centres or food vendors. Since addressing the risk factors of NCDs involves long-term behavioural change, ownership of health policies by local communities can ensure the success and sustainability of nutrition and preventive health programmes. The participation of local communities ensures that health policies and programmes are better targeted to their health needs. Including children's involvement and input in school lunch programmes can help identify options that are both healthy and appealing to children, and has often shown that the perception that children prefer unhealthy options is inaccurate.[72] Local participation by residents of low-income areas may help provide an assessment of foods available in those areas that is more reflective of the day-to-day experiences of residents than expert-formulated surveys would be able to establish. Likewise, educating and involving consumers and informal sector food vendors in healthy food programmes can improve nutrition in a sector that is otherwise difficult to regulate, while also allowing such vendors to maintain their livelihoods.

VIII. Accountability and remedies

50. States have an obligation to make legislative, judicial and administrative mechanisms available, accessible and effective to enable people to hold States and non-State actors accountable and claim remedies for violations of their right to health. Omission by States to legislate and enforce regulatory frameworks with respect to the food industry may in itself be a violation of the right to health. For instance, if the State fails to put into place laws requiring the provision and dissemination of information, people may not be in a position to make informed choices about their diet, which may prevent them from realizing their highest attainable standard of health.

51. States should not only ensure that relevant laws and policies are in place, but also that they are formulated, implemented and monitored in a transparent manner, in line with the right to health. Transparency should be ensured at all times, including when negotiating international obligations. Although transparency is required by some investment treaties, it is linked to the promotion and protection of international investment.[73] The thrust is towards ensuring that laws and regulations, which may affect investments, are made

[72] Katherine Bauer *et al.*, "'How can we stay healthy when you're throwing all of this in front of us?' Findings from focus groups and interviews in middle schools on environmental influences on nutrition and physical activity", *Health Education and Behavior*, vol. 31, No. 1 (February 2004), pp. 40–41.

[73] World Trade Organization, Principles of the trading system, http://www.wto.org/english/thewto_e/whatis_e/tif_e/fact2_e.htm.

publicly available to the contracting parties. Some international organizations have adopted transparency principles that pertain, however, to the predictability of investment rules and regulations[74] to protect the commercial interest of contracting parties, which benefits the private commercial interests of TNCs. Furthermore, these treaties are negotiated in secret without any discussion at the domestic level, which is not compatible with the right to health framework.[75]

52. Commercial investment treaties cast obligations that are automatically binding on States. To abide by these obligations, States may be compelled to modify national policies such as agricultural or labelling policies. As a result, the function of States to formulate domestic policy gets distorted in favour of the private rights of food and beverage industries, rather than the public rights of the affected population.[76] The right to health framework, on the other hand, requires transparency in activities that directly or indirectly affect governance. It acts as a check against arbitrary decisions that may be taken by States and pre-empts violations of the right to health. One of the ways in which States could ensure transparency is by opening negotiations to include affected people such as farmers and consumers. At minimum, States should make the content of negotiations and agreements available for public scrutiny and invite comments by stakeholders before entering into these agreements.

53. Accountability can also be ensured through indicators, benchmarks and targets against which the performance of State and non-State actors in achieving goals to reduce risk and prevalence of NCDs can be monitored and evaluated.[77] As multiple agencies of the State may be involved in regulating activities of the food industry and the provision of nutritious food,[78] information outlining their individual and joint efforts towards attaining the set benchmarks should be made public. Making information available to the public and independent monitoring bodies will enable them to assess the activities of the food industry and their compliance with domestic marketing, labelling and nutrition standards and laws. States should also encourage monitoring of other non-State actors such as private schools and broadcasting agencies to review their policy *vis-à-vis* the food industry. Review and evaluation of actions taken and standards adopted by States and non-State actors to ensure the sale and availability of nutritious foods comprise the accountability framework.

54. Due to the increased prevalence of NCDs and their link to practices adopted by the food industry, access to remedies is necessary. Judicial remedies to hold TNCs accountable for the violations of the right to health are particularly hard to achieve. Investment treaties such as bilateral investment treaties and free trade agreements, which facilitate the foray and entrenchment of TNCs into domestic economies, contain international dispute settlement mechanisms that allow private companies to sue States. However, these treaties

[74] ASEAN [Association of Southeast Asian Nations] Comprehensive Investment Agreement, Article 1 (c). Available from http://aseansummit.mfa.go.th/14/pdf/Outcome_Document/ASEAN%20Compre%20Invest%20Agreement.pdf.

[75] Sharon Friel *et al.*, "A new generation of trade policy: potential risks to diet-related health from trans Pacific partnership agreement", *Globalization and Health*, vol. 9, No. 46 (2013), p. 2.

[76] Sarah E. Clark *et al.*, "Exporting obesity: US farm and trade policy and the transformation of the Mexican consumer food environment", *International Journal of Occupational and Environmental Health*, vol. 18, No. 1 (2012), p. 54.

[77] WHO, Draft comprehensive global monitoring framework and targets for the prevention and control of noncommunicable diseases, A66/8. Available from http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_8-en.pdf.

[78] Michael R. Taylor, "Preparing America's food safety system for the twenty-first century", *Resources*, No. 127 (spring 1997), p. 16. Available from http://rff.org/Documents/Resources/Resources-127_Taylor.pdf.

impose unilateral obligations on host States, so that it becomes difficult to bring TNCs into their domestic legal system, including the judicial system. Moreover, the principles of limited liability and separate legal personalities are often relied upon by parent companies to absolve themselves of any liability of their subsidiaries operating in various jurisdictions.[79] Even where remedies against domestic companies exist, their enforcement is often absent or lax, and companies are not penalized for non-compliance. Consumers should be able to seek remedies against food companies, irrespective of the country of origin of the parent company. States should therefore clarify under domestic law the liability of the parent company and its subsidiaries.

55. Remedies for violations of the right to health should be available from States as well. In cases where States have not enshrined the right to health obligation in the domestic legal system, adjudicatory mechanisms should exist for people to claim remedies against the State and hold it accountable for failing to respect, protect and fulfil the right to health. In cases where States neglect to take steps to fulfil international commitments to reduce the burden of NCDs, including diet-related NCDs, people should have access to domestic and thereafter international mechanisms to claim remedies against States for not taking steps towards this goal. Ensuring access to a range of remedies, in the form of restitution, compensation, satisfaction or guarantees of non-repetition, is an effective way to hold State and non-State actors accountable for violations of the right to health.

IX. International assistance and cooperation

56. Under the right to health framework, States should extend their assistance and cooperation to full realization of the right to health. While entering into international agreements, States should ensure that such agreements do not negatively impact on the enjoyment of the right to health.

57. Giving primacy to international trade over the right to health has widespread repercussions on public health.[80] For instance, under international trade agreements, States have sometimes expressed concerns about requirements in other States' domestic nutrition labelling policies, which have been instituted to attain public health goals.[81] Such practices may restrict the policy space of developing countries in favour of attracting FDI and avoiding economic sanctions.[82] Bilateral investment treaties may subvert existing internationally agreed upon guidelines and lower tariff and non-tariff barriers to trade, allowing freer import and export of unhealthy food products. For instance, free trade agreements have been directly linked to an increased consumption of soft drinks.[83]

58. Investment agreements may also contain provisions that allow States to be sued for taking measures to protect public health that may adversely impact investments of the contracting party and private corporations. The mere threat of onerous and expensive

[79] Gwynne Skinner *et al.*, *The Third Pillar: Access to Judicial Remedies for Human Rights Violations by Transnational Business* (ICAR/CORE/ECCJ, 2013), p. 11. Available from http://accountabilityroundtable.org/wp-content/uploads/2013/02/The-Third-Pillar-Access-to-Judicial-Remedies-for-Human-Rights-Violation-by-Transnational-Business.pdf.

[80] Kelley Lee and Meri Koivusalo, "Trade and health: is the health community ready for action?", *PLOS Medicine*, vol. 2, No. 1 (2005), p. 14.

[81] World Trade Organization, "Members discuss guidelines for trade-friendly regulation and STOP sign for 'junk food'", 13 March 2013, available from http://www.wto.org/english/news_e/news13_e/tbt_13mar13_e.htm.

[82] WHO, *Trade, Trade Agreements and Non-Communicable Diseases in the Pacific Islands* (2013), p. 10.

[83] "Manufacturing epidemics" (see footnote 10 above), p.6.

litigation may create a chilling effect where States would refrain from formulating such policies in the first place.[84] In order to reduce the global and domestic burden of NCDs and ensure that health concerns override trade relations, States need to collaborate by supporting localized and suitable food systems and ensuring that domestic policy space on nutritional systems is protected.[85] When entering into investment agreements, host States should take assertive steps and mention clear and explicit exceptions to investments that may harm public health.[86]

59. In addition, States should extend their assistance to low- and middle-income countries, which, due to their limited resources, may be unable to attain required nutrition standards, leading to an increased burden of NCDs.[87] In such cases, States should extend their assistance through technology transfer, capacity-building and, where necessary, by providing monetary support (A/RES/66/2). This will help ensure that States lacking sufficient expertise develop and sustain the requisite technology to take preventive actions against NCDs.

60. Political commitment towards diet-related NCDs at the international level has so far been weak. NCDs have traditionally not been given importance in international policies, including the Millennium Development Goals.[88] International aid agencies providing health-related assistance to low- and middle-income countries have not sufficiently prioritized NCDs there.[89] Only recently have international and regional organizations shifted their focus and called upon Governments, the private sector and non-governmental organizations to come together to take steps towards prevention of NCDs across regions.[90] In formulating the post-2015 development agenda, States have commendably shown unprecedented political will to address the reduction and prevention of NCDs,[91] and Governments have been urged to reduce the burden of NCDs by 2025.[92] There is increasing recognition among Governments of the link between unhealthy diets and NCDs and the challenges they pose for development (A/RES/66/2).

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[84] "A new generation of trade policy" (see footnote 78 above), p. 5.

[85] Joint statement of Asia–Pacific Economic Cooperation (APEC) Ministers at the 2010 APEC Ministerial Meeting, Yokohama, 11 November 2010. Available from http://www.apec.org/Meeting-Papers/Ministerial-Statements/Annual/2010/2010_amm.aspx.

[86] Anne Marie Thowa and Benn McGrady, "Protecting policy space for public health nutrition in an era of international investment agreements", *Bulletin of the World Health Organization*, vol. 92 p. 142. Available from http://www.who.int/bulletin/volumes/92/2/13-120543.pdf.

[87] NCD Alliance, "Food, nutrition, diet and non-communicable diseases", available from http://www.wcrf.org/PDFs/PPA_NCD_Alliance_Nutrition.pdf.

[88] Shanthi Mendis, "The policy agenda for prevention and control of non-communicable diseases", *British Medical Bulletin*, vol. 96, No. 1 (2010), p. 37.

[89] G.F. Anderson, "Missing in action: international aid agencies in poor countries to fight chronic disease", *Health Affairs*, vol. 28, No. 1 (January–February 2009), pp. 202–203.

[90] Prevention and control of non-communicable diseases: Report of the Secretary-General (A/66/83); Pan American Health Organization, *CARMEN: an Initiative for Integration of Prevention of Noncommunicable Diseases in the Americas* (Washington D.C., 2003). Available from http://www.paho.org/carmen/wp-content/uploads/2012/06/CARMEN-General-Overview.pdf.

[91] A new global partnership: eradicate poverty and transform economies through sustainable Development: report of the High-Level Panel of Eminent Persons on the Post-2015 Development Agenda, p. 38. Available from http://www.un.org/sg/management/pdf/HLP_P2015_Report.pdf.

[92] WHO, *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020* (Geneva, 2013), Objective 3, pp. 31–32. Available from http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf?ua=1.

61. An effective international framework is needed to hold the global food industry legally accountable for its actions.[93] There is a need to create an international framework that binds States and casts responsibility on them to modify their domestic laws for reduction and prevention of diet-related NCDs. The Framework Convention on Tobacco Control could be used as a foundation on which an international framework for accountability and monitoring of the food and beverage industry can be built. The international community also needs to ensure that food corporations driven by commercial interests do not undermine the efforts of States to realize the enjoyment of the highest attainable standard of health.

62. However, mere political consensus may not be sufficient to attain a reduction in diet-related NCDs. States, intergovernmental organizations and non-governmental organizations should come together to combat this epidemic. States need to have a time-bound plan outlining concrete steps to be taken individually and jointly to progressively attain a global and domestic reduction in the burden of diet-related NCDs. To operationalize this goal, States should formulate indicators, benchmarks and global and domestic accountability mechanisms. States should also allocate sufficient resources to reduce and prevent the obesity epidemic as well as the increasing burden of diet-related NCDs.

X. Conclusion and recommendations

63. **In keeping with their obligations to respect, protect and fulfil the right to health, States should formulate and implement a national public health strategy and plan of action to address diet-related NCDs, which should be widely disseminated. Such a strategy should recognize the link between unhealthy foods and NCDs, while specifically addressing the structural flaws in food production, marketing and retail that promote the availability and accessibility of unhealthy foods over healthier options. Towards this end, States should necessarily develop multisectoral approaches that include all relevant ministries such as ministries of health, agriculture, finance, industry and trade. States should also ensure meaningful and effective participation of affected communities such as farmers and vulnerable groups like children, women and low-income groups in all levels of decision-making to discourage production and consumption of unhealthy foods and promote the availability and accessibility of healthier food options.**

64. **With a view to respecting, protecting and fulfilling the right to health, the Special Rapporteur recommends that States take the following steps:**

(a) Increase availability and accessibility of healthier food alternatives through fiscal and agricultural policies that discourage production of unhealthy foods. Also take measures to incentivize farmers to grow healthier products;

(b) Make nutritious and healthy foods available and geographically and economically accessible, especially to low-income groups;

(c) Provide information about the ill effects of unhealthy foods and raise awareness of the benefits of balanced diets and healthy foods to promote consumption of healthier foods;

[93] Human Rights Watch, "UN Human Rights Council: weak stance on business standards", 16 June 2011, available from http://www.hrw.org/news/2011/06/16/un-human-rights-council-weak-stance-business-standards.

(d) Adopt, implement and enforce easy-to-understand labelling and nutritional profiling requirements, such as "traffic light" labelling;

(e) Encourage TNCs, through incentives and other fiscal measures, to manufacture and sell healthier alternatives of foods and beverages that are not harmful to the people's health;

(f) Regulate the marketing, advertisement and promotion of unhealthy foods, particularly to women and children, to reduce their visibility and to increase the visibility of healthier options by, for instance, requiring supermarkets to place fruits and vegetables in more accessible and visible places.

65. With a view to ensuring their obligation to realize the right to health of vulnerable groups such as children, women and low-income groups, the Special Rapporteur recommends that States take the following steps:

(a) Address gender stereotypes in preparation of meals that place an unequal burden of cooking on women;

(b) Formulate and implement health education programmes to promote healthy food options in such institutional settings as schools, health or youth centres and workplaces by involving children, parents and employees, respectively;

(c) Ensure that social welfare schemes for low-income groups make relevant information available and provide access to healthier food options to eliminate "food deserts".

66. Recognizing the role of the food industry in the growing burden of NCDs, the Special Rapporteur recommends that the food industry take the following steps:

(a) Adopt internationally acceptable nutritional labelling guidelines and comply with domestically-enacted guidelines in this respect;

(b) Refrain from marketing, promoting and advertising of unhealthy foods to the population, especially to children;

(c) Invest in improving the nutritional content of unhealthy foods;

(d) Increase transparency of nutritional information on food products, while desisting from making false and misleading health claims;

(e) Abstain from undermining public health nutrition efforts, including through such means as funding and publicizing biased research, instituting front groups and conducting expensive and onerous litigation.

67. With a view to making accountability and remedial mechanisms available and accessible to victims of violations, the Special Rapporteur recommends that States take the following steps:

(a) Ensure that international investment and trade agreements are entered into with full transparency and participation of affected groups by conducting open discussions before, during and after negotiation of the agreements;

(b) Encourage and promote independent monitoring of activities of the State and the food industry. Urge participation of affected people and local communities in monitoring such activities;

(c) Ensure remedies through legislation and appropriate mechanisms against States and non-State actors for failure to take steps towards their obligations under the right to health and to fulfil their international commitments on reduction of diet-related NCDs.

68. **With regard to the international obligations of States, the Special Rapporteur recommends that States take the following steps:**

(a) Accord primacy to the right to health in international investment and trade agreements, and ensure that the right to health is not impaired by the provisions of these agreements or their implementation;

(b) Extend assistance and cooperation to other States, which, due to limited resources available to them, may be unable to attain required nutrition standards, leading to an increased burden of diet-related NCDs;

(c) Formulate goals and take concrete steps, jointly and individually, to reduce the burden of diet-related NCDs in a manner that also takes into account available resources of each State.